Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-1587-01

MFDR Date Received
January 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration, which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule §133.240 [sic]. The request for reconsideration and this MDR are being filed in order to comply with the requirements of RULE §133.250(B) and RULE §133.305."

Amount in Dispute: $265.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier representative box number 19 on January 26, 2011. The DWC060 was stamped received on January 28, 2011 by FOL Fileroom Gordon Clayton. An audit will be conducted based on the documentation contained in the file at the time of the review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2010	99204 and 99080	$265.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 guidelines for Medical Bill Submission by Health Care Provider.
3. The requestor did not submit EOBs with the DWC060 request.

Issues

1. Did the requestor submit the bill to the employer?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20 states in pertinent part, "(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031."

   Review of the CMS-1500s indicates that the requestor submitted the bills to the injured employee's employer "McRoberts Security."
2. As a result, the requestor is not entitled to reimbursement for the disputed CPT codes 99204-25 and 99080-73 rendered on February 11, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 4, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.